



Preferred Drug List (PDL) and Drugs Requiring Prior Authorization (PA)

05/01/08

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Phone Numbers for Vermont Medicaid PBM Program

MedMetrics Health Partners (MHP)**Clinical Call Center:****PA Requests**

Tel: 1-800-918-7549; Fax: 1-866-767-2649

Note: Fax requests are responded to within 24 hrs.

For urgent requests, please call MHP directly.

MHP Program Rep-Vermont:

Assistance with any issues related to the PBM program.

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Acne Drugs: Oral

Length of Authorization: 1 year

NO PA REQUIRED

DOXYCYCLINE† 20 mg, 50 mg, 75 mg, 100 mg tab, cap

ERY-TAB® (erythromycin base, delayed release)

ERYTHROCIN† (erythromycin stearate)

ERYTHROMYCIN BASE†

ERYTHROMYCIN ESTOLATE†

ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S.®, Eryped®)

ERYTHROMYCIN STEARATE†

MINOCYCLINE† 50 mg, 75 mg, 100 mg

TETRACYCLINE† 250 mg, 500 mg cap

SUMYCIN† 250 mg, 500 mg cap

ISOTRETINOIN† 10 mg, 20 mg, 40 mg cap (SOTRET, CLARAVIS, AMNESTEEM)

PA REQUIRED

Adoxa®* (doxycycline monohydrate) 50 mg, 75 mg tab, 100 mg tab, 150 mg tab

Adoxa Pak®* (doxycycline monohydrate) 1/75 mg, 1/100 mg, 1/150 mg, 2/100 mg

Doryx®* (doxycycline hyclate) 75 mg, 100 mg cap
doxycycline monohydrate pak† (compare to Adoxa Pak®) 1/75 mg, 1/100 mg, 1/150 mg, 2/100 mg

Monodox®* (doxycycline monohydrate) 50 mg, 100 mg cap

Oracea® (doxycycline monohydrate) 40 mg cap

Periostat®* (doxycycline hyclate) 20 mg, 100 mg tab

Vibramycin®* (doxycycline hyclate) 50 mg, 100 mg cap

Vibramycin® (doxycycline hyclate) suspension

Vibratab®* (doxycycline hyclate) 100 mg tab

All other brands

E.E.S.®* (erythromycin ethylsuccinate)

Eryc®* (erythromycin base, delayed release)

Eryped® (erythromycin ethylsuccinate)

PCE Dispertab® (erythromycin base)

All other brands

Minocin®* (minocycline) 50 mg, 75 mg, 100 mg cap

Dynacin®* (minocycline) 50 mg, 75 mg, 100 mg cap/tab

Solodyn® (minocycline) 45 mg, 90 mg, 135 mg tabs

All other brands

Sumycin® (tetracycline) 250 mg, 500 mg tab

Sumycin® (tetracycline) 125 mg/5ml syrup

All other brands

Accutane®* (isotretinoin) 10 mg, 20 mg, 40 mg caps

All other brands

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Acne Drugs: Topical Anti-Infectives

Length of Authorization: 1 year

NO PA REQUIRED

BENZOYL PEROXIDE PRODUCTS

BENZOYL PEROXIDE 2.5%, 5%, 10% G, L, W; 10% C; 3%, 5%, 6%, 8%, 9%, 10% L; 3%, 6%, 9% P †

CLINDAMYCIN PRODUCTS

CLINDAMYCIN 1% S, G, L, P †

ERYTHROMYCIN PRODUCTS

ERYTHROMYCIN 2% S, G, P †

SODIUM SULFACETAMIDE PRODUCTS

SODIUM SULFACETAMIDE 10% L†

COMBINATION PRODUCTS

ERYTHROMYCIN / BENZOYL PEROXIDE†

SODIUM SULFACETAMIDE / SULFUR L†

SODIUM SULFACETAMIDE / SULFUR W†

OTHER

PA REQUIRED

Benzac AC® 2.5%, 5%, 10% G, W
 Benzashave® 5%, 10% C
 Brevoxyl® 4%, 8% W; 4% G; 4%, 8% L
 Clinac BPO® 7% G
 Desquam-E/X® 2.5%, 5%, 10% G; 5%, 10% W
 Inova 4% P
 Panoxyl/AQ 2.5%, 5%, 10% G; 5%, 10% B
 Triaz® 3%, 6%, 9% G; 3%, 6%, 9% P
 Zaclair® 4%, 8% L
 All other brands

Cleocin-T®* (clindamycin 2% G)
 Evoclin® (clindamycin 2% F)
 Clindagel® (clindamycin 1% G)
 All other brands

Akne-Mycin® (erythromycin 2% O)
 Erygel®* (erythromycin 2% G)
 All other brands

Klaron®* (sodium sulfacetamide 10% L)
 All other brands

Benzaclen®, DUAC® (clindamycin/benzoyl peroxide)
 Benzamycin®* (erythromycin/benzoyl peroxide)
 Sulfoxy (erythromycin/benzoyl peroxide)
 Z-Clinz® (clindamycin/benzoyl peroxide kit)
 All other brands

Avar® (sodium sulfacetamide/sulfur G)
 Plexion® (sulfacetamide/sulfur S)
 Rosac®* (sulfacetamide/sulfur W)
 Rosula®* (sulfacetamide/sulfur W)
 Sulfacet-R®* (sodium sulfacetamide/sulfur L)
 Plexion® (sulfacetamide/sulfur S)
 All other brands

Azelex® (azelaic acid 20% C)
 All other brands any topical acne anti-infective medication

C=cream, E=emulsion, F=foam, G=gel, L=lotion, O=ointment, P=pads, S=solution, W=wash, B=bar

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Acne Drugs: Topical – Retinoids

Length of Authorization: 1 year

NO PA REQUIRED

TRETINOIN† (specific criteria required for ages <10 or >34) 0.025%, 0.05%, 0.1% C; 0.01%, 0.025% G

TAZORAC® (tazarotene) 0.05%, 0.1% C, G

C=cream, G=gel

PA REQUIRED

All brand tretinoin products (Atralin® 0.05% G, Avita®*, Retin-A®*, Retin-A Micro® 0.1%, 0.04%, Tretin-X® etc.)

Differin® (adapalene) 0.1% C, G; 0.3% G

Avage® (tazarotene) ♣

Renova® (tretinoin) ♣

Solage® (tretinoin/mequinol) ♣

Tri-Luma® (tretinoin/hydroquinone/fluocinolone) ♣

♣ Not indicated for acne. Coverage of topical retinoid products will not be approved for cosmetic use (wrinkles, age spots, etc.).

Acne Drugs: Topical – Rosacea

Length of Authorization: 1 year

NO PA REQUIRED

METRONIDAZOLE† 0.75% C, G, L

C=cream, G=gel, L=lotion

PA REQUIRED

All brand metronidazole products (MetroCream®* 0.75% C, MetroGel®* 0.75% G, MetroGel® 1% G, MetroLotion®* 0.75% L, Noritate® 1% C, Rozex® 0.75% G etc.)

Finacea® (azelaic acid) 15% G

Alzheimer's Medications: Cholinesterase Inhibitors/NMDA Receptor Antagonists

Length of Authorization: 1 year

NO PA REQUIRED

CHOLINESTERASE INHIBITORS

ARICEPT® (donepezil) Tablet (QL = 1 tablet/day)
EXELON® (rivastigmine) Capsule (QL = 2 capsules/day)

ARICEPT® ODT (donepezil) (QL = 1 tablet/day)

EXELON® (rivastigmine) Oral Solution

EXELON® (rivastigmine transdermal) Patch (QL = 1 patch/day)

NMDA RECEPTOR ANTAGONIST

NAMENDA® (memantine) Tablet

NAMENDA® (memantine) Oral Solution

PA REQUIRED

Cognex® (tacrine) Capsule §
Razadyne® (galantamine) Tablet §
Razadyne ER® (galantamine) Capsule §

Razadyne® (galantamine) Oral Solution §

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Analgesics: COX-2 Inhibitors

Length of Authorization: 1 year

NO PA REQUIRED

CELEBREX® (celecoxib) (age ≥ 60 yrs) (*QL* = 2 capsules/day)

PA REQUIRED

Celebrex® (age < 60 yrs) (*QL* = 2 capsules/day)

Analgesics: Narcotics-Short Acting

Length of Authorization: 3 months, subsequent approval up to 6 months

Quantity limits apply

NO PA REQUIRED

ACETAMINOPHEN W/CODEINE† (compare to Tylenol® w/codeine)
ACETAMINOPHEN W/HYDROCODONE† (compare to Vicodin®, Loracet®, Maxidone®, Norco®, Zydome®)
(*QL* 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)
ACETAMINOPHEN W/OXYCODONE† (compare to Percocet®)
(*QL* 10/650 = 6 tablets/day)
ACETAMINOPHEN W/PROPOXYPHENE† (compare to Darvocet-N®)
(*QL* 100/650 = 6 tablets/day)
ASPIRIN W/CODEINE†
ASPIRIN W/OXYCODONE† (compare to Percodan®)
BUTALBITAL COMP. W/CODEINE† (compare to Fiorinal® w/codeine)
CODEINE SULFATE†
DIHYDROCODEINE COMPOUND† (compare to Synalgos-DC®)
HYDROCODONE† (plain, w/acetaminophen, or w/ibuprofen)
HYDROMORPHONE† (compare to Dilaudid®)
MEPERIDINE† (compare to Demerol®) (30 tabs or 5 day supply)
MORPHINE SULFATE†
MORPHINE SULFATE† (compare to Roxanol®)
OXYCODONE† (plain, w/acetaminophen or w/ibuprofen)
PENTAZOCINE† (compare to Talwin®)
PROPOXYPHENE† (compare to Darvon®)
PROPOXYPHENE COMPOUND.† (compare to Darvon Compound®)
PROPOXYPHENE N W/ ACETAMINOPHEN†
ROXICET® (oxycodone w/ acetaminophen)
ROXICODONE INTENSOL® (oxycodone w/ acetaminophen)
ROXICODONE® (oxycodone HCL)
TRAMADOL† (compare to Ultram®)
TRAMADOL/APAP† (compare to Ultracet®)

PA REQUIRED

Acetaminophen w/ codeine: *all branded products*
Acetaminophen w/ hydrocodone: *all branded products*
(*QL* 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)
Acetaminophen w/ oxycodone: *all branded products*
(*QL* 10/650 = 6 tablets/day)
Actiq® (fentanyl lozenge on a stick: 200 mcg, 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg)
Anexsia®*
Bancap HC®
Butorphanol Nasal Spray (*QL* = 2 units/month)
Capital® w/Codeine*
Combunox®* (oxycodone w/ibuprofen)
Darvocet-N®* (*QL* 100/650 = 6 tablets/day)
Darvon Compound®*
Darvon®/ Darvon-N®*
Dazidox®*(oxycodone)
Demerol®
Dilaudid®*
Endocet®
Endodan®
fentanyl citrate† transmucosal (compare to Actiq®)
Fentora® (fentanyl citrate buccal tablets)
Fioricet w/codeine®*
Liquicet®* (hydrocodone w/acetaminophen)
Lorcet®* (also HD, PLUS)
Lortab®*
Magnacet®
Maxidone®
Meperidine (*Qty* > 30 tabs or 5 day supply)
Nalbuphine
Norco®*
Nubain®*
Numorphan®
Opana®
Oxyfast®*
OxyIR®*
Panlor DC®
Pentazocine and Naloxone
Percocet®*
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Percodan®*

Propoxyphene: *all branded products**

Roxanol®*

Synalgos DC®*

Talacen®*

Talwin®* and brand combinations/ Talwin NX®*

Trezix®

Tylenol® #3*

Tylenol® #4*

Tylox®*

Ultracet®

Ultram®*

Ultram ER®

Vicodin®*

Vicoprofen®*

Wygesic®*

Xodol®

Zydone®*

Analgesics: Narcotics-Long Acting

Length of Authorization: initial approval 3 months, subsequent approval up to 6 months

Quantity limits apply

Therapy Specific PA fax form for Long Acting Narcotics available on OVHA web-site.

NO PA REQUIRED

TRANSDERMAL

FENTANYL PATCH† (compare to Duragesic®) 25 mcg/hr, 50 mcg/hr,
(QL=15 patches/30 days)

FENTANYL PATCH† (compare to Duragesic®) 75 mcg/hr, 100 mcg/hr,
(QL=30 patches/30 days)

ORAL

METHADONE† (compare to Dolophine®) 5 mg, 10 mg

MORPHINE SULFATE ER† (compare to MS Contin®)
(QL=90 tablets/strength/30 days)

PA REQUIRED

Duragesic-12® 12.5 mcg/hr (QL=15 patches/30 days)

Duragesic®* 25 mcg/hr, 50 mcg/hr, (QL=15 patches/30 days)

Duragesic®* 75 mcg/hr, 100 mcg/hr (QL= 30 patches/30 days)

Fentanyl Patch† (compare to Duragesic®) 12.5 mcg/hr (QL=15 patches/30 days)

Avinza® (morphine sulfate XR) (QL= 30 capsules/strength/30 days)

Dolophine®* (methadone)

Kadian® (morphine sulfate XR) (QL= 60 capsules/strength/30 days)

Methadone 40 mg Dispersible Tablets §

MS Contin®* (morphine sulfate ER) (QL=90 tablets/strength/30 days)

Opana ER® (oxymorphone ER) (QL=60 tablets/strength/30 days)

Oramorph SR®* (morphine sulfate ER) (QL=90 tablets/strength/30 days)

Oxycodone ER† (QL=90 tablets/strength/30 days)

OxyContin® (QL= 90 tablets/strength/30 days)

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Analgesics: NSAIDs

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

DICLOFENAC POTASSIUM† (compare to Cataflam®)
DICLOFENAC SODIUM† (compare to Voltaren®)
DIFLUNISAL† (compare to Dolobid®)
ETODOLAC†
FENOPROFEN† (compare to Nalfon®)
FLURBIPROFEN† (compare to Ansaid®)
IBUPROFEN† (compare to Motrin®)
INDOMETHACIN†(compare to Indocin®)
KETOPROFEN†
KETOPROFEN ER†
MECLOFENAMATE SODIUM† (compare to Meclofenamate Sodium®)
NABUMETONE†
NAPROXEN† (compare to Naprosyn®)
NAPROXEN SODIUM† (compare to Anaprox®, Naprelan®)
OXaprozin† (compare to Daypro®)
PIROXICAM† (compare to Feldene®)
SULINDAC† (compare to Clinoril®)
TOLMETIN SODIUM†

PA REQUIRED

Anaprox®*
Anaprox DS®*
Ansaid®*
Arthrotec®
Cataflam®*
Clinoril®*
Daypro®*
Dolobid®*
EC-Naprosyn® *
Feldene®*
Indocin®*
Indocin SR®
Ketorolac† *QL = 20 doses post PA approval*
Meloxicam† (compare to Mobic®)
Mefenamic acid† (compare to Ponstel®)
Mobic®
Motrin®*
Nalfon®*

Naprelan®*
Naprosyn®*
Ponstel®
Voltaren®*
Voltaren XR® *

Anemia: Hematopoietic/Erythropoietic Agents

Length of Authorization: 1 year

NO PA REQUIRED

ARANESP® (darbepoetin alfa)
PROCRIT® (epoetin alpha)

PA REQUIRED

EpoGen® (epoetin alpha)

Ankylosing Spondylitis: Injectables

Length of Authorization: Initial PA 3 months; 12 months thereafter

Therapy-specific PA fax form available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL® (etanercept)
HUMIRA® (adalimumab)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Remicade® (infliximab)

Anti-anxiety: Anxiolytics

Length of Authorization: 1 year

NO PA REQUIRED

ALPRAZOLAM† (compare to Xanax®)
ALPRAZOLAM XR† (compare to Xanax XR®)
BUSPIRONE† (compare to Buspar®)
CHLORDIAZEPoxide† (compare to Librium®)
CLONAZEPAM† (compare to Klonopin®)
CLONAZEPAM ODT† (compare to Klonopin Wafers®)
CLORAZEPATE† (compare to Tranxene®)
DIAZEPAM† (compare to Valium®)
LORAZEPAM† (compare to Ativan®)
MEPROBAMATE†
OXAZEPAM† (compare to Serax®)

PA REQUIRED

Ativan®*
Buspar®*
Klonopin®*
Klonopin Wafers®
Librium®*
Niravam® (alprazolam ODT)
Serax®*
Tranxene®* (all brand forms)
Valium®*
Xanax®*
Xanax XR®

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Anticoagulants

Length of Authorization: 6 months

Quantity limits apply

NO PA REQUIRED

WARFARIN (compare to Coumadin®)

HEPARIN

FRAGMIN® (dalteparin)

LOVENOX® (enoxaparin) (*QL = 2 syringes/day calculated in ml volume*)

ARIXTRA® (fondiparinux)

PA REQUIRED

Coumadin® (warfarin)

n/a

Innohep® (tinzaparin)

Anticonvulsants

Length of Authorization: Lifetime for Seizure Disorders, Duration of Need for Mental Health Indications, 1 Year for Other Indications

NO PA REQUIRED

CARBAMAZEPINE† (compare to Tegretol®)

CARBATROL® (carbamazepine)

CELONTIN® (methsuxamide)

CLONAZEPAM† (compare to Klonopin®)

CLONAZEPAM ODT† (compare to Klonopin Wafers®)

DEPAKOTE® (divalproex sodium)

DEPAKOTE ER® (divalproex sodium)

DIASSTAT® (diazepam rectal gel)

DILANTIN® (phenytoin)

EPITOL† (carbamazepine)

ETHOSUXAMIDE† (compare to Zarontin®)

FELBATOL® (felbamate)

GABAPENTIN† (compare to Neurontin®)

GABITRIL® (tiagabine)

KEPPRA® (levetiracetam)

LAMICTAL® tabs (lamotrigine tabs)

LAMICTAL® chew tabs (lamotrigine chew tabs)

NEURONTIN® oral solution (gabapentin)

PEGANONE® (ethotoxin)

PHENYTOIN® (phenytoin)

PHENYTOIN† (compare to Dilantin®)

PRIMIDONE† (compare to Mysoline®)

TEGRETOL XR® (carbamazepine)

TOPAMAX® (topiramate)

TRILEPTAL® (oxcarbazepine)

VALPROIC ACID† (compare to Depakene®)

ZONISIMIDE† (compare to Zonegran®)

PA REQUIRED

Depakene®* (valproic acid)

Gabarone®* (gabapentin)

Klonopin®*

Klonopin Wafers®*

lamotrigine† chew tabs (compare to Lamictal® chew tabs)

Lyrica® (pregabalin) § (*Quantity Limit = 3 capsules/day*)

Mysoline®* (primidone)

Neurontin®* (gabapentin)

oxcarbazepine † (compare to Trileptal®)

Tegretol®* (carbamazepine)

Zarontin®* (ethosuxamide)

Zonegran®* (zonisamide)

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Anti-depressants: Novel

Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications

Quantity limits apply

Suggested daily dosage limits

NO PA REQUIRED

BUDEPRION®/BUPROPION SR† (compare to Wellbutrin SR®)
suggested max dose = 400 mg/day
 BUPROPION† (compare to Wellbutrin®)
 MAPROTILINE† (compare to Ludomil®)
 MIRTAZAPINE† (compare to Remeron®) *suggested max dose = 90 mg/day*
 MIRTAZAPINE RDT† (compare to Remeron Sol-Tab®) *suggested max dose = 90 mg/day*
 NEFAZADONE† (compare to Serzone®) *suggested max dose = 750 mg/day*
 TRAZODONE HCL† (compare to Desyrel®) *suggested max dose = 750 mg/day*
 WELLBUTRIN XL®

PA REQUIRED

Budeprion XR/bupropion XL† (compare to Wellbutrin XL®)
 Cymbalta®
 Desyrel®* *suggested max dose = 750 mg/day*
 Effexor®
 Effexor XR®§ *suggested max dose = 450 mg/day,
 QL = 1 cap/day (37.5 mg & 75 mg caps)*
 Remeron®* *suggested max dose = 90 mg/day*
 Remeron Sol Tab®* *suggested max dose = 90 mg/day*
 venlafaxine IR §
 Wellbutrin®*
 Wellbutrin SR®* *suggested max dose = 400 mg/day*

Anti-depressants: SSRIs

Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications

Quantity limits apply

Suggested daily dosage limits

NO PA REQUIRED

CITALOPRAM† (compare to Celexa®) *suggested max dose = 75 mg/day*
 FLUOXETINE† (compare to Prozac®) *suggested max dose = 100 mg/day*
 FLUVOXAMINE† (compare to Luvox®) *suggested max dose = 300 mg/day*
 PAROXETINE tablet† (compare to Paxil®) *suggested max dose = 75 mg/day*
 SERTRALINE† (compare to Zoloft®) *suggested max dose = 250 mg/day,
 QL = 1.5 tabs/day (25 mg & 50 mg tabs)*

PA REQUIRED

Celexa®* *suggested max dose = 75 mg/day*
 Lexapro® *suggested max dose = 25 mg/day,
 QL = 1.5 tabs/day (5 mg & 10 mg tabs)*
 Luvox®* *suggested max dose = 300 mg/day*
 paroxetine suspension† (compare to Paxil® susp) *suggested max dose = 75 mg/day*
 Paxil®* *suggested max dose = 75 mg/day*
 Paxil CR® *suggested max dose = 75 mg/day*
 Pexeva® *suggested max dose = 75 mg/day*
 Prozac®* *suggested max dose = 100 mg/day*
 Prozac Weekly® *suggested max weekly dose = 540 mg*
 Sarafem® *suggested max dose = 100 mg/day*
 Zoloft® *suggested max dose = 250 mg/day, QL = 1.5 tabs/day (25 mg & 50 mg tabs)*

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Anti-depressants: Tricyclics

Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications

Suggested daily dosage limits

NO PA REQUIRED

AMITRIPTYLINE† (compare to Elavil®) suggested max dose = 375 mg/day
AMITRIPTYLINE/CHLORDIAZ.† (compare to Limbitrol®)
AMITRIPTYLINE/PERPHEN†.(compare to Etrafon®, Triavil®)
AMOXAPINE† (compare to Asendin®)
CLOMIPRAMINE† (compare to Anafranil®)
DESIPRAMINE† (compare to Norpramin®)
DOXEPIN† (compare to Sinequan®)
IMIPRAMINE† (compare to Tofranil®) suggested max dose = 250 mg/day
NORTRIPTYLINE† (compare to Aventyl®, Pamelor®)
TOFRANIL PM® (imipramine pamoate)
TRIMIPRAMINE† (compare to Surmontil®)
VIVACTIL® (protriptyline)

PA REQUIRED

Anafranil®*
Aventyl®*
Elavil®*
Limbitrol®*
Limbitrol DS®
Norpramin®*
Pamelor®*
Sinequan®*
Surmontil®*
Tofranil®*

Anti-depressants: MAO Inhibitors

Length of Authorization: Duration of Need for Mental Health Indications

Quantity limits apply

Suggested daily dosage limits

NO PA REQUIRED

NARDIL® (phenylzine) suggested max dose = 110 mg/day
TRANYLCPROMINE† (compare to Parnate®) suggested max dose = 120 mg/day

PA REQUIRED

EMSAM® (selegiline) (QL = 1 patch/day)
Marplan® (isocarboxazid)
Parnate®*

Anti-diabetics: Alpha-Glucosidase Inhibitors

Length of Authorization: n/a

NO PA REQUIRED

GLYSET® (miglitol)
PRECOSE® (acarbose)

PA REQUIRED

Anti-diabetic: Biguanides & Combinations

Length of Authorization: 1 year

NO PA REQUIRED

GLIPIZIDE/METFORMIN† (compare to Metaglip®)
GLYBURIDE/METFORMIN† (compare to Glucovance®)
METFORMIN† (compare to Glucophage®)
METFORMIN XR† (compare to Glucophage XR®)
RIOMET® (metformin oral solution)

PA REQUIRED

Fortamet®
Glucophage®*
Glucophage XR®*
Glucovance®*
Glumetza®
Metaglip®*

Anti-diabetics: Peptide Hormones

Length of Authorization: 1 year

Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Byetta® (exenatide) § (Quantity Limit = 1 pen/30 days)

PA REQUIRED

Symlin® (pramlintide) No Quantity Limit

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Anti-diabetics: Insulins

Length of Authorization: lifetime

NO PA REQUIRED

RAPID-ACTING INJECTABLE

NOVOLOG® (Aspart)

PA REQUIRED

Apidra® (insulin glulisine)
Humalog® (insulin lispro)

SHORT-ACTING INJECTABLE

NOVOLIN R® (Regular)

Humulin R® (Regular)
ReliOn R® (Regular)

INTERMEDIATE-ACTING INJECTABLE

NOVOLIN N® (NPH)

Humulin N® (NPH)
ReliOn N® (NPH)

LONG-ACTING ANALOGS INJECTABLE

LANTUS® (insulin glargine)
LEVEMIR® (insulin detemir)

MIXED INSULINS INJECTABLE

HUMULIN 50/50® (NPH/Regular)
NOVOLIN 70/30® (NPH/Regular)

Humulin 70/30® (NPH/Regular)
ReliOn 70/30® (NPH/Regular)

NOVOLOG MIX 70/30® (Protamine/Aspart)

HUMALOG MIX 50/50® (Protamine/Lispro)
HUMALOG MIX 75/25® (Protamine/Lispro)

INHALED

Exubera® (insulin human [rDNA] Inhalation Powder)

Anti-diabetic: Oral Meglitinides

Length of Authorization: 1 year

NO PA REQUIRED

STARLIX® (nateglinide)

PA REQUIRED

Prandin® (replaglinide)

Anti-diabetic: Sulfonylureas 2nd Generation

Length of Authorization: 1 year

NO PA REQUIRED

GLIMEPIRIDE† (compare to Amaryl®)
GLIPIZIDE† (compare to Glucotrol®)
GLIPIZIDE ER† (compare to Glucotrol XL®)
GLYBURIDE† (compare to Diabeta®, Micronase®)
GLYBURIDE MICRONIZED† (compare to Glynase® PresTab®)

PA REQUIRED

Amaryl®*
Diabeta®*
Glucotrol®*
Glucotrol XL®*
Glynase® PresTab®*
Micronase®*

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Anti-diabetic: Thiazolidinediones & Combinations

Length of Authorization: 1 year

Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

SINGLE AGENT

ACTOS®(pioglitazone) §
AVANDIA® (rosiglitazone) §

COMBINATION

ACTOPLUS MET® (metformin/pioglitazone) §
AVANDAMET® (metformin/rosiglitazone maleate) §
AVANDARYL® (glimepiride/rosiglitazone maleate) §
DUETACT® (pioglitazone/glimepiride) § (*Quantity Limit = 1 tablet/day*)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Anti-diabetic: Dipeptidyl Peptidase (DPP-4) Inhibitors

Length of Authorization: 1 year

Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

JANUVIA® (sitagliptin) § (*Quantity Limit = 1 tablet/day*)
JANUMET® (sitagliptin/metformin) § (*Quantity Limit = 2 tablets/day*)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Anti-emetics: NK1/5HT3 Antagonists

Length of Authorization: 6 months for chemotherapy or radiotherapy;

1 time for prevention of post-op nausea/vomiting: see clinical criteria.

Monthly quantity limits apply, PA required to exceed.

NO PA REQUIRED

EMEND® (aprepitant) 40 mg (1 cap/30 days)
*EMEND® (aprepitant) 80 mg (2 caps/30 days)
*EMEND® (aprepitant) 125 mg (1 cap/30 days)
*EMEND® (aprepitant) Tri-fold Pack (1 pack/30 days)
ONDANSETRON† Injection (vial and premix)
ONDANSETRON†tablet 4 mg (12 tabs/month), 8 mg (6 tabs/month)
ONDANSETRON† ODT 4 mg (12 tabs/month), 8 mg (6 tabs/month)

* To be prescribed by oncology practitioners ONLY

PA REQUIRED

Aloxi® (palonosetron, injectable) (2 vials/month)
Anzemet® (dolasetron) 50 mg (4 tabs/month)
Anzemet® (dolasetron) 100 mg (2 tabs/month)
Gransetron† (compare to Kytril®) 1 mg (6 tabs/month)
Gransetron† (compare to Kytril®) Injectable
Gransetron† (compare to Kytril®) Oral Solution
Kytril® (gransetron) 1 mg (6 tabs/month)
Kytril® (gransetron) Injectable
Ondansetron† (generic) 24 mg (1 tab/month)
Ondansetron† (generic) Oral Solution 4 mg/5 ml
Zofran®* (ondansetron) Injection
Zofran®* (ondansetron) Oral Tablets and ODT 4 mg (12 tabs/month),
8 mg (6 tabs/month)
Zofran® (ondansetron) Oral Solution 4 mg/5 ml

Anti-emetics: Other

Length of Authorization: Initial approval 3 months, subsequent approval up to 6 months

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Marinol®(dronabinol) (*Quantity Limit = 30 days supply for AIDS anorexia or quantity required for one chemotherapy treatment course*)

Cesamet® (nabilone) (*Quantity Limit = quantity required for one chemotherapy treatment course*)

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Antihyperkinesis: ADHD, ADD, Narcolepsy

Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications
CNS Stimulants (all forms short- & long-acting): PA'd for beneficiaries < 3 yrs
Quantity limits apply

NO PA REQUIRED

SHORT/INTERMEDIATE ACTING METHYLPHENIDATE PREPS

METADATE ER® (compare to Ritalin® SR)
METHYLIN® (compare to Ritalin®)
METHYLIN® ER (compare to Ritalin® SR)
METHYLPHENIDATE† (compare to Ritalin®)
METHYLPHENIDATE SR† (compare to Ritalin® SR)

PA REQUIRED

Dexmethylphenidate (compare to Focalin®)
Focalin® (dexmethylphenidate)
Ritalin®*
Ritalin SR®*

LONG-ACTING METHYLPHENIDATE PREPS

FOCALIN® XR (dexmethylphenidate IR/ER, 50:50%)
CONCERTA® (methylphenidate IR/ER 22:78%)
DAYTRANA® (methylphenidate patch) (*QL = 1 patch/day*)

Metadate CD® (methylphenidate, IR/ER, 30:70%)
Ritalin LA® (methylphenidate, IR/ER, 50:50%)

SHORT/INTERMEDIATE AMPHETAMINE PREPS

AMPHETAMINE salt combination† (compare to Adderall®)
DEXTROAMPHETAMINE†
DEXTROAMPHETAMINE CR† (compare to Dexedrine CR®)
DEXTROSTAT†

Adderall®*
Desoxyn® (methamphetamine)
Dexedrine®* (CR)

LONG-ACTING AMPHETAMINE PREPS

ADDERALL XR® (dextroamphetamine IR/ER, 50:50%)
VYVANSE® (lisdexamfetamine) (*QL = 1 capsule/day*)

NON-STIMULANT PREPS

Provigil® (modafinil) (**not approvable for ADHD in children age ≤ 12**)
Strattera® (atomoxetine) *max dose = 100 mg/day*

Xyrem® (sodium oxybate)

Anti-hypertensives: ACE Inhibitors

Length of Authorization: 1 year

NO PA REQUIRED

BENAZEPRILO† (compare to Lotensin®)
CAPTOPRIL† (compare to Capoten®)
ENALAPRIL† (compare to Vasotec®)
FOSINOPRIL† (compare to Monopril®)
LISINOPRIL† (compare to Zestril®, Prinivil®)
MOEXIPRIL† (compare to Univasc®)
QUINAPRIL† (compare to Accupril®)

PA REQUIRED

Accupril®*
Aceon® (perindopril)
Altace® (ramipril)
Capoten®*
Lotensin®*
Mavik® (trandolapril)
Monopril®*

Prinivil®*
ramipril† (compare to Altace®)
trandolapril† (compare to Mavik®)
Univasc®* (moexipril)
Vasotec®*
Zestril®*

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Anti-hypertensives: ACE Inhibitor with Hydrochlorothiazide

Length of Authorization: 1 year

NO PA REQUIRED

BENAZEPRIL/HYDROCHLOROTHIAZIDE† (compare to Lotensin HCT®)
 CAPTOPRIL/HYDROCHLOROTHIAZIDE† (compare to Capozide®)
 ENALAPRIL/HYDROCHLOROTHIAZIDE† (compare to Vaseretic®)
 FOSINOPRIL/HYDROCHLOROTHIAZIDE† (compare to Monopril HCT®)
 LISINOPRIL/HYDROCHLOROTHIAZIDE† (compare to Zestoretic®, Prinzide®)
 QUINAPRIL/HYDROCHLOROTHIAZIDE† (compare to Accuretic®)

PA REQUIRED

Accuretic®*
 Capozide®*
 Lotensin HCT®*
 moexipril/hydrochlorothiazide† (compare to Uniretic®)
 Monopril HCT®*
 Prinzide®*
 Uniretic® (moexipril/hydrochlorothiazide)
 Vaseretic®*
 Zestoretic®*

Anti-hypertensives: ACE Inhibitor w/Calcium Channel Blocker

Length of Authorization: 1 year

NO PA REQUIRED

benazepril/amlodipine † (compare to Lotrel®)

PA REQUIRED

Lexxel® (enalapril/felodipine)
 Lotrel® (benazepril/amlodipine)
 Tarka® (trandolopril/verapamil)

Anti-hypertensives: Angiotensin Receptor Blockers (ARBs)

Length of Authorization: lifetime

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

AVAPRO® (irbesartan) §
 BENICAR® (olmesartan) §
 COZAAR® (losartan) §
 DIOVAN® (valsartan) §
 MICARDIS® (telmisartan) §

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Atacand® (candesartan) §
 Teveten® (eprosartan) §

Anti-hypertensives: Angiotensin Receptor Blocker/Hydrochlorothiazide Combinations

Length of Authorization: lifetime

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

AVALIDE® (irbesartan/hydrochlorothiazide) §
 BENICAR HCT® (olmesartan/hydrochlorothiazide) §
 DIOVAN HCT® (valsartan/hydrochlorothiazide) §
 HYZAAR® (losartan/hydrochlorothiazide) §
 MICARDIS HCT® (telmisartan/hydrochlorothiazide) §

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Atacand HCT® (candesartan/hydrochlorothiazide) §
 Teveten HCT® (eprosartan/hydrochlorothiazide) §

Anti-hypertensives: Angiotensin Receptor Blocker/Calcium Channel Blocker Combinations

Length of Authorization: lifetime

Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

EXFORGE® (valsartan/amlodipine) § (*Quantity Limit = 1 tablet/day*)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Azor® (olmesartan/amlodipine) (*Quantity Limit = 1 tablet/day*)

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Anti-hypertensives: Beta Blockers

Length of Authorization: 5 years

NO PA REQUIRED

SINGLE AGENT

ACEBUTOLOL† (compare to Sectral®)
 ATENOLOL† (compare to Tenormin®)
 BETAXOLOL† (compare to Kerlone®)
 BISOPROLOL FUMARATE† (compare to Zebeta®)
 CARVEDILOL† (compare to Coreg®)
 LABETALOL† (compare to Normodyne®, Trandate®)
 METOPROLOL† (compare to Lopressor®)
 METOPROLOL XL† (compare to Toprol XL®)
 NADOLOL† (compare to Corgard®)
 PINDOLOL† (compare to Visken®)
 PROPRANOLOL† (compare to Inderal®)
 SOTALOL† (compare to Betapace®, Betapace AF®)
 TIMOLOL† (compare to Blocadren®)

BETA-BLOCKER/DIURETIC COMBINATION

ATENOLOL/CHLORTHALIDONE † (compare to Tenoretic®)
 BISOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Ziac®)
 METOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Lopressor HCT®)
 PROPRANOLOL/HYDROCHLOROTHIAZIDE† (compare to Inderide®)

PA REQUIRED

Betapace®*
 Betapace AF®*
 Blocadren®*
 Cartrol®
 Coreg®
 Coreg CR®
 Corgard®
 Inderal®* (all products)
 Inderal LA®
 Innopran XL®

Corzide®
 Inderide®*
 Lopressor HCT®*
 Nadolol/bendroflumethiazide†
 (compare to Corzide®)

Kerlone®*
 Levatol® (penbutolol)
 Lopressor®* (all products)
 propranolol ER† (compare to
 Inderal LA®)
 Sectral®*
 Tenormin®*
 Timolide®
 Toprol XL®* (metoprolol succinate)
 Trandate®*
 Zebeta®*

Anti-hypertensives: Calcium Channel Blockers

Length of Authorization: 5 years

Quantity limits apply

NO PA REQUIRED

AMLODIPINE† (compare to Norvasc®)
 CARTIA XT®(diltiazem HCL)
 DILTIA XT®(diltiazem HCL)
 DILTIAZEM† (compare to Cardizem®)
 DILTIAZEM ER† (compare to Cardizem® SR)
 DILTIAZEM CD† (compare to Cardizem® CD)
 DILTIAZEM XR† (compare to Dilacor® XR)
 FELODIPINE† (compare to Plendil®)
 NICARDIPINE† (compare to Cardene®)
 NIFEDIAC® CC (compare to Adalat CC®)
 NIFEDICAL XL† (compare to Procardia® XL)
 NIFEDIPINE IR† (compare to Procardia®)
 NIFEDIPINE ER† (compare to Procardia® XL)
 NIMODIPINE† (compare to Nimotop®)
 TAZTIA XT® (compare to Tiazac®)
 VERAPAMIL† (compare to Calan®)
 VERAPAMIL CR† (compare to Calan SR®, Isoptin SR®)
 VERAPAMIL SR† 120 mg, 180 mg 240 mg and 360 mg (compare to
 Verelan®)

EXFORGE® (valsartan/amlodipine) § (*Quantity Limit = 1 tablet/day*)

PA REQUIRED

Adalat® CC*
 Calan®*
 Calan® SR*
 Cardene®*
 Cardene® SR (no AB rated generic)
 Cardizem®*, Cardizem® CD*
 Cardizem® LA (no AB rated generic)
 Covera-HS® (no AB rated generic)
 Dilacor® XR*
 Dynacire CR® (no AB rated generic)
 Isoptin® SR*
 isradipine†
 Nimotop®* (nimodipine)
 Norvasc®* (amlodipine)
 Plendil®*
 Procardia®*
 Procardia® XL*
 Sular® (nisoldipine)
 Tiazac®*
 verapamil SR †100 mg, 200 mg, 300mg (compare to Verelan PM®)
 Verelan®*
 Verelan PM®

Azor® (olmesartan/amlodipine) (*Quantity Limit = 1 tablet/day*)
 Caduet® (amlodipine/atorvastatin)

PDL Key:

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Anti-hypertensives: Renin Inhibitor

Length of Authorization: lifetime

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

TEKTURNA® (aliskiren) §

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Anti-infectives: Cephalosporins – 1st Generation

Length of Authorization: for date of service, no refills

NO PA REQUIRED

CEFADROXIL† (compare to Duricef®)
CEPHALEXIN† (compare to Keflex®)

IV drugs are not managed at this time

PA REQUIRED

Duricef®*
Keflex®*

Anti-infectives: Cephalosporins – 2nd Generation

Length of Authorization: for date of service, only: no refills

NO PA REQUIRED

TABLETS
CEFACLOR CAPSULE†
CEFACLOR ER TABLET†
CEFPROZIL TABLET† (compare to Cefzil®)
CEFUXOME TABLET† (compare to Ceftin®)

SUSPENSION

CEFACLOR SUSPENSION†
CEFPROZIL SUSPENSION† (compare to Cefzil®)
CEFTIN® (cefuroxime) SUSPENSION

IV drugs are not managed at this time

PA REQUIRED

Ceftin®* tablet
Cefzil® tablet
Lorabid® (loracarbef) capsule

Cefuroxime† Suspension (compare to Ceftin®)
Cefzil® suspension
Lorabid® (loracarbef) suspension

Anti-infectives: Cephalosporins – 3rd Generation

Length of Authorization: for date of service, no refills

NO PA REQUIRED

CAPSULES/TABLETS
CEFPODOXIME PROXETIL TABS† (compare to Vantin®)
OMNICEF® CAPSULE (cefdinir)

SUSPENSION

OMNICEF® SUSPENSION (cefdinir)
SUPRAX® SUSPENSION (cefixime)

IV drugs are not managed at this time

PA REQUIRED

Cedax® capsule (ceftibuten)
cefdinir capsule†
Spectracef® tablet (cefditoren)
Vantin®* tablet (cefpodoxime)

Cedax® suspension (ceftibuten)
cefdinir suspension †
cefpodoxime proxetil† (compare to Vantin®) suspension
Vantin® suspension (cefpodoxime)

Anti-infectives: Ketolides

Length of Authorization: for date of service, no refills

NO PA REQUIRED

PA REQUIRED

Ketek® (telithromycin)

PDL Key:

† Generic product

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Anti-infectives: Macrolides

Length of Authorization: for date of service, no refills

NO PA REQUIRED

AZITHROMYCIN† tablets (≤ 5 day supply) (compare to Zithromax®)
AZITHROMYCIN† liquid (≤ 5 day supply) (compare to Zithromax®)

CLARITHROMYCIN† (compare to Biaxin/Biaxin XL)

ERY-TAB® (erythromycin base, delayed release)
ERYTHROCIN† (erythromycin stearate)
ERYTHROMYCIN BASE†
ERYTHROMYCIN ESTOLATE†
ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S.®, Eryped®)
ERYTHROMYCIN STEARATE†
ERYTHROMYCIN W/ SULFASOXAZOLE† (compare to Pedazole®)
IV drugs are not managed at this time

PA REQUIRED

azithromycin† tablets and liquid (if > 5 day supply)
Biaxin®*
Biaxin XL®
Dynabac® (dirithromycin)
E.E.S.®*
Eryc®* (erythromycin base, delayed release)
Eryped® (erythromycin ethylsuccinate)
PCE Dispersatab® (erythromycin base)
Pedazole®* (erythromycin-sulfisoxazole)
Zithromax® tablets and liquid
Zmax® (azithromycin extended release oral suspension)

Anti-infectives: Oxazolidinones

Length of Authorization: 28 days, no refills

Quantity Limits Apply

NO PA REQUIRED

IV form of this medication not managed at this time

PA REQUIRED

Zyvox® (linezolid) (QL = 56 tablets per 28 days)

Anti-infectives: Penicillins (Oral)

Length of Authorization: for date of service, no refills

NO PA REQUIRED

AMOXICILLIN† (compare to Amoxil®, Trimox®, DisperMox™)
AMOXICILLIN/CLAVULANATE† (compare to Augmentin®)
AMPICILLIN† (compare to Principen®)
DICLOXA CILLIN†
PENICILLIN VK† (compare to Veetids®)

PA REQUIRED

Augmentin®*
Augmentin ES®*
Augmentin XR®

* PA will be granted for 125 mg/5 mL strength for patients < 12 weeks of age

Anti-infectives: Quinolones

Length of Authorization: for date of service, no refills

NO PA REQUIRED

CIPROFLOXACIN† (compare to Cipro®)
CIPRO® OS (ciprofloxacin oral solution) 100 mg/ml
LEVAQUIN® (levofloxacin)
OFLOXACIN†

PA REQUIRED

Avelox® (moxifloxacin HCL)
Avelox ABC PACK® (moxifloxacin HCL)
Cipro®*
Cipro XR®
ciprofloxacin ER†
Factive® (gemifloxacin)
Noroxin® (norfloxacin)
ProQuin XR® (ciprofloxacin)

IV drugs are not managed at this time

PDL Key:

† Generic product

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Anti-infectives: Antifungal: Allylamines

Length of Authorization: Up to 3 months

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

terbinafine† tabs (compare to Lamisil®) *QL = 30 tablets/month*
Lamisil® tablets (terbinafine HCL) *QL = 30 tablets/month*

Anti-infectives: Antifungal: Azoles

Length of Authorization: Up to 3 months

NO PA REQUIRED

FLUCONAZOLE† (compare to Diflucan®)
KETOCONAZOLE† (compare to Nizoral®)

IV drugs are not managed at this time.

PA REQUIRED

itraconazole† (compare to Sporanox®)
Sporanox® (itraconazole)
VFend® (voriconazole)
Diflucan®* (fluconazole)
Nizoral®* (ketoconazole)
Noxafil® (posaconazole)

Anti-infectives: Antifungal: Topical: Onychomycosis

Length of Authorization: 1 year

Monthly quantity limits apply

NO PA REQUIRED

PA REQUIRED

Ciclopirox † 8 % solution (compare to Penlac® Nail Lacquer)
QL = 6.6 ml/90 days
Penlac® Nail Lacquer (ciclopirox 8 % solution) *QL = 6.6 ml/90 days*

Anti-infectives: Anti-virals: Herpes (Oral)

Length of Authorization: for duration of prescription, up to 6 months.

NO PA REQUIRED

ACYCLOVIR† (compare to Zovirax®)
VALTREX® (valacyclovir)

PA REQUIRED

Famciclovir † (compare to Famvir®)
Famvir® (famciclovir) §
Zovirax®* §

Anti-infectives: Influenza Medications

Length of Authorization: for duration of prescription, up to 3 months.

Quantity limits apply

NO PA REQUIRED (During Flu Season Nov 1st – March 31st)

RELENZA® (zanamivir) *QL = 20 blisters / 30 days*
TAMIFLU® (oseltamivir) *QL = 10 capsules/30 days(45 mg & 75 mg caps)*
 20 capsules / 30 days (30 mg caps)
 75 ml / 30 days (suspension)

PA REQUIRED

amantadine† PA for quantity ≤ 10 days supply (Not CDC recommended for use in influenza)
Flumadine® (rimantadine) (Not CDC recommended for use in influenza)
rimantadine† (Not CDC recommended for use in influenza)
Symmetrel® (amantadine) (Not CDC recommended for influenza)

Anti-infectives: Influenza Vaccines

Length of Authorization: for date of service only

NO PA REQUIRED

AFLURIA® Injection
FLUARIX® Injection
FLUZONE® Injection
FLUVIRIN® Injection

PA REQUIRED

FluMist® Nasal

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

Anti-infectives: Miscellaneous

Length of Authorization: 1 year

NO PA REQUIRED

PA REQUIRED

Qualaquin® (quinine sulfate)

Anti-infectives: Topical Antibiotics

Length of Authorization: for date of service, no refills

Quantity limits apply

NO PA REQUIRED

BACITRACIN†
 GENTAMICIN†
 BACITRACIN-POLYMICIN†
 NEOMYCIN-BACITRACIN-POLYMICIN†
 CORTISPORIN®
 BACTROBAN® OINTMENT
 MUPIROCIN OINTMENT (compare to Bactroban®)

PA REQUIRED

Altabax® (retapamulin) (*Quantity Limit = 1 tube*)
 Bactroban® CREAM

Anti-migraine: Triptans

Length of Authorization: 6 months

Monthly quantity limits apply, PA required to exceed.

NO PA REQUIRED, Quantity Limits Apply

AXERT® (almotriptan) 6.25 mg, 12.5 mg (*QL = 6 tabs/month*)
 IMITREX® (sumatriptan) Injection 6 mg (*QL = 4 injections/month*)
 IMITREX® NS (sumatriptan) 20 mg (*QL = 6 units/month*)
 IMITREX® NS (sumatriptan) 5 mg (*QL = 12 units/month*)
 IMITREX® (sumatriptan) 25 mg (*QL = 18 tabs/month*)
 IMITREX® (sumatriptan) 50 mg, 100 mg (*QL = 9 tabs/month*)
 MAXALT-MLT® (rizatriptan ODT) 5 mg, 10 mg (*QL = 12 tabs/month*)
 MAXALT® (rizatriptan) 5 mg, 10 mg (*QL = 12 tabs/month*)

PA REQUIRED, Quantity Limits Apply

Amerge® (naratriptan) 1 mg, 2.5 mg (*QL = 9 tabs/month*)
 Frova® (frovatriptan) 2.5 mg (*QL = 9 tabs/month*)
 Relpax® (eletriptan) 20 mg, 40 mg (*QL = 12 tabs/month*)
 Zomig® (zolmitriptan) ZMT 2.5 mg (*QL = 12 tabs/month*),
 5 mg (*QL = 6 tabs/month*)
 Zomig® 2.5 mg (*QL = 12 tabs/month*)
 Zomig® 5 mg (*QL = 6 tabs/month*)
 Zomig® Nasal Spray (*QL = 12 units/month*)

Anti-obesity

*Length of Authorization: 6 months for initial approval,
 may renew for additional 6 months if patient has met target goals.*

Quantity limits apply

Therapy specific PA fax form available on OVHA website.

NO PA REQUIRED

PA REQUIRED

Alli® (orlistat OTC) *QL = 3 capsules/day*
 benzphetamine† (all forms brand & generic)
 diethylpropion† (all forms brand & generic)
 Meridia® (sibutramine)
 phentermine† (all forms brand & generic)
 phendimetrazine† (all forms brand & generic)
 Xenical® (orlistat)

PDL Key:

† Generic product

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Anti-psychotic: Atypical & Combinations

Length of Authorization: Duration of Need

Quantity limits apply

Suggested daily dosage limits

NO PA REQUIRED

CLOZAPINE† (compare to Clozaril®) suggested max dose = 1125 mg/day

GEODON® (ziprasidone) suggested max dose = 200 mg/day

RISPERDAL® (risperidone) suggested max dose = 10 mg/day

SEROQUEL® (quetiapine) suggested max dose = 1000 mg/day

RISPERDAL® (risperidone) oral solution suggested max dose=10 mg/day

GEODON IM® (ziprasidone Injectable)

PA REQUIRED

Abilify® (aripiprazole) suggested max dose = 40 mg/day,
QL = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)

Clozaril®* suggested max dose = 1125 mg/day

Invega® (paliperidone) QL = 1 tab/day (3mg, 9mg), 2 tabs/day (6mg)

Seroquel® XR (quetiapine) QL = 1 tab/day (200 mg tab strength only)

Zyprexa® (olanzapine) suggested max dose = 50 mg/day,
QL = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg, & 10 mg tabs)

Abilify® (aripiprazole) oral solution suggested max dose = 40 mg/day

Abilify® IM (aripiprazole intramuscular injection)
Zyprexa® IM (olanzapine intramuscular injection)

Risperdal Consta® (risperidone microspheres)

Abilify® Discmelt (aripiprazole) suggested max dose = 40 mg/day, Quantity limit = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)

Fazaclor® (clozapine orally disintegrating tablet) suggested max dose = 1125 mg/day

Risperdal M-Tab® (risperidone orally disintegrating tablet) suggested max dose = 10 mg/day

Zyprexa Zydis® (olanzapine orally disintegrating tablet) suggested max dose = 50 mg/day, QL = 1.5 tabs/day (5 mg & 10 mg tabs)

Symbax® (olanzapine/fluoxetine)

Anti-psychotic: Typicals

Length of Authorization: Duration of Need for Mental Health Indications

NO PA REQUIRED

CHLORPROMAZINE† (compare to Thorazine®)

FLUPHENAZINE† (compare to Prolixin®, Prolixin®)

HALOPERIDOL† (compare to Haldol®)

LOXAPINE† (compare to Loxitane®)

MOBAN® (molindone)

PERPHENAZINE† (compare to Trilafon®)

THIORIDAZINE† (compare to Mellaryl®)

THIOTHIXENE† (compare to Navane®)

TRIFLUOPERAZINE† (compare to Stelazine®)

PA REQUIRED

Haldol®*

Loxitane®*

Mellaril®*

Navane®*

Prolixin®*

Thorazine®*

Trilafon®*

Botulinum toxins

Length of Authorization: Initial Approval 3 months, Subsequent approval up to 12 months

NO PA REQUIRED

PA REQUIRED

Botox®

Botox® Cosmetic

Myobloc®

PDL Key:

† Generic product

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BPH: Alpha Blockers

Length of Authorization: 1 year

NO PA REQUIRED

DOXAZOSIN† (compare to Cardura®)
FLOMAX® (tamsulosin)
TERAZOSIN† (compare to Hytrin®)
UROXATRAL® (alfuzosin)

PA REQUIRED

Cardura®*, Cardura XL®
Hytrin®*

BPH: Androgen Hormone Inhibitors

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

AVODART® (dutasteride) (*QL = 1 capsule/day*)
FINASTERIDE† (compare to Proscar®) (*QL = 1 tablet/day*)
PROSCAR® (finasteride) (*QL = 1 tablet/day*)

PA REQUIRED

Avodart® (dutasteride) females; males age < 45 (*QL = 1 capsule/day*)
finasteride† (compare to Proscar®) females; males age < 45 (*QL = 1 tablet/day*)
Proscar® (finasteride) females; males age < 45 (*QL = 1 tablet/day*)

Cardiac Glycosides

Length of Authorization: n/a

NO PA REQUIRED

DIGITEK® (digoxin)
DIGOXIN†
LANOXICAPS® (digoxin)
LANOXIN® (digoxin)

PA REQUIRED

Chemical Dependency: Alcohol and Opiate Dependency

Length of Authorization: Vivitrol – 6 months, no renewal, All Others 1 year

DATA 2000 Waiver ("X" number) required for prescribers of Buprenorphine

Quantity limits apply

Vivitrol and Buprenorphine Therapy specific PA fax forms are available on OVHA website.

NO PA REQUIRED

Alcohol Dependency
ANTABUSE® (disulfiram)
CAMPRAL® (acamprosate)
NALTREXONE oral † (compare to Revia®)

PA REQUIRED

Revia®* (naltrexone oral)
Vivitrol® (naloxone for extended-release injectable suspension) (*QL = 1 injection (380 mg) per 30 days*)

Revia®* (naltrexone oral)
Suboxone® (buprenorphine with naloxone): 2 mg/0.5 mg and 8 mg/2 mg tablet
Subutex® (buprenorphine): 2 mg and 8 mg tablets

Opiate Dependency

NALTREXONE oral † (compare to Revia®)

Note: Methadone for opiate dependency can only be prescribed through a Methadone Maintenance Clinic

Constipation: Chronic

Length of Authorization: 3 months

NO PA REQUIRED

Bulk-Producing Laxatives
PSYLLIUM†
Osmotic Laxatives
LACTULOSE†
POLYETHYLENE GLYCOL 3350 (PEG)† (compare to Miralax®)

PA REQUIRED

Amitiza® (lubiprostone)

PDL Key:

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Contraceptives: Vaginal Ring

Length of Authorization: n/a

NO PA REQUIRED

NUVARING® (etonogestrel/ethinyl estradiol vaginal ring)

PA REQUIRED

Coronary Vasodilators/Antianginals: Oral

Length of Authorization: 3 years

Quantity limits apply

NO PA REQUIRED

ISOSORBIDE DINITRATE† tablet (compare to Isordil®)
ISOSORBIDE DINITRATE† SL tablet
ISOSORBIDE DINITRATE† ER tablet
ISOSORBIDE MONONITRATE† tablet (compare to Ismo®, Monoket®)
ISOSORBIDE MONONITRATE† ER tablet (compare to Imdur®)
NITROGLYCERIN† SL tablet
NITROGLYCERIN† ER capsule
NITROLINGUAL PUMP SPRAY®
NITROGARD® BUCCAL
NITROQUICK® (nitroglycerin SL tablet)
NITROSTAT® (nitroglycerin SL tablet)
NITRO-TIME® (nitroglycerin ER capsule)

PA REQUIRED

Dilatrate-SR® (isosorbide dinitrate SR capsule)
Imdur®* (isosorbide mononitrate ER tablet)
Ismo®* (isosorbide mononitrate tablet)
Isordil®* (isosorbide dinitrate tablet)
Monoket®* (isosorbide mononitrate tablet)

BiDil® (isosorbide dinitrate/hydralazine)

Ranexa® (ranolazine) (*Quantity Limit = 3 tablets/day (500 mg), 2 tablets/day (1000 mg))*)

Coronary Vasodilators/Antianginals: Topical

Length of Authorization: 3 years

NO PA REQUIRED

NITREK® (nitroglycerin transdermal patch)
NITRO-BID® (nitroglycerin ointment)
NITROGLYCERIN TRANSDERMAL PATCHES† (compare to Nitro-Dur®)

PA REQUIRED

Nitro-Dur®* (nitroglycerin transdermal patch)

Cough and Cold Preparations

Length of Authorization: for date of service, no refills

Effective May 1, 2008 PA required for Age < 2 years old for all cough and cold (brand and generic)

NO PA REQUIRED

All generics
MUCINEX® (guaifenesin)

PA REQUIRED

Tussionex® (hydrocodone/chlorpheniramine) (*Quantity Limit = 60 ml*)
All other brands

Dermatological Agents: Genital Wart Therapy

Length of Authorization: 1 month

NO PA REQUIRED

ALDARA® (imiquimod)

PA REQUIRED

PODOFILOX SOLUTION† (compare to Condylox®)

Condylor® Gel (podofilox gel)
Condylor®* solution (podofilox solution)

PDL Key:

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Dermatological Agents: Scabicides and Pediculocides

Length of Authorization: date of service only, no refills

NO PA REQUIRED

EURAX® (crotamiton) C, L
NIX® (permethrin) CR, G, Sp
permethrin† (compare to Elimite®) C
permethrin† L
piperonyl butoxide and pyrethrins† G, S, Sh
RID® (piperonyl butoxide and pyrethrins) G, Sh, Sp

All other brand and generic Scabicides and Pediculicides

PA REQUIRED

Elimite®* (permethrin 5 %) C
Lindane† L, Sh
Ovide® (malathion) L

Desmopressin: Intranasal

Length of Authorization: 2 years

NO PA REQUIRED

PA REQUIRED

DDAVP® (desmopressin) Nasal Solution or Spray 0.01%
Desmopressin † Nasal Solution or Spray 0.01 % (compare to DDAVP®)
Minirin † (desmopressin) Nasal Spray 0.01%
Stimate® (desmopressin) Nasal Solution 1.5 mg/ml

Diabetic Testing Supplies

Length of Authorization: 5 years

NO PA REQUIRED

DIABETIC MONITORS/METERS
FREESTYLE LITE® SYSTEM KIT
FREESTYLE FLASH® SYSTEM KIT
FREESTYLE FREEDOM® SYSTEM KIT
FREESTYLE FREEDOM LITE® SYSTEM KIT
ONE TOUCH® ULTRA 2 KIT
ONE TOUCH® ULTRA MINI KIT
ONE TOUCH® ULTRA SMART KIT
PRECISION XTRA® METER

PA REQUIRED

Accuchek®
Ascensia®
Assure®
Exactech®
Prodigy®

All other brands and store brands

DIABETIC TEST STRIPS

FREESTYLE®*
FREESTYLE LITE®*
ONE TOUCH® BASIC*
ONE TOUCH® SURESTEP*
ONE TOUCH® FAST TAKE*
ONE TOUCH® UL®TRA*
PRECISION XTRA®*
PRECISION XTRA® BETA KETONE (10 count)

Accuchek®
Ascensia®
Assure®
Exactech®
Prodigy®

All other brands and store brands

* 50 and 100 count package sizes

Gastrointestinal: Crohn's Disease Injectables

Length of Authorization: Initial PA 3 months; 12 months thereafter

Therapy-specific PA fax form available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

HUMIRA® (adalimumab)
REMICADE® (infliximab)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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Gastrointestinals: H2-blockers

Length of Authorization: 1 year

NO PA REQUIRED

CIMETIDINE† (compare to Tagamet®) tablet
FAMOTIDINE† (compare to Pepcid®) tablet
RANITIDINE† (compare to Zantac®) tablet

PA REQUIRED

Axid® (nizatidine) capsule §
nizatidine† (compare to Axid®) capsule §
Pepcid®* (famotidine) tablet §
ranitidine† capsule §
Tagamet®* tablet §
Zantac®* tablet §

SYRUPS AND SPECIAL DOSAGE FORMS

CIMETIDINE † ORAL SOLUTION
ZANTAC® (ranitidine) SYRUP

Axid® (nizatidine) Oral Solution §
Pepcid® Oral Suspension §
ranitidine† syrup§
Zantac Effervescent® §

Gastrointestinals: Inflammatory Bowel Agents (Oral and Rectal Products)

Length of Authorization: 1 year

NO PA REQUIRED

Mesalamine Products
ASACOL® (mesalamine tablet delayed-release)
CANASA® (mesalamine suppository)
LIALDA® (mesalamine tablet extended-release)
MESALAMINE ENEMA† (compare to Rowasa®)
PENTASA® (mesalamine cap CR)

PA REQUIRED

Rowasa®* (mesalamine enema)

Other

BALSALAZIDE† (compare to Colazal®)
DIPENTUM® (olsalazine)
SULFASALAZINE† (compare to Azulfidine®)

Azulfidine®* (sulfasalazine)
Colazal®* (balsalazide)

Gastrointestinals: Proton Pump Inhibitors

Length of Authorization: up to 1 year

Quantity limits apply

▲ No PA required for patients <16 years; Quantity Limits still apply.

▲ No PA required for patients < 12 years; Quantity Limits still apply.

NO PA REQUIRED FOR ONCE DAILY DOSES

PREVACID® (lansoprazole) capsules (Quantity Limit=1 capsule/day)
PREVACID® (lansoprazole) packets (Quantity Limit=1 packet/day)
PRILOSEC OTC® (omeprazole magnesium) No Quantity Limit
PROTONIX® (pantoprazole) (Quantity Limit=1 tablet/day)

PA REQUIRED

AcipHex® (rabeprazole) § Qty Limit=1 tablet/day
Nexium® (esomeprazole) capsules§ Qty Limit=1 capsule/day
Nexium® (esomeprazole) powder for suspension § (Qty limit=1 packet/day)
omeprazole† generic♣ RX capsules § Qty Limit=1 capsule/day
omeprazole† generic♣ OTC tablets § Qty Limit=1 tablet/day
pantoprazole† generic tablets Qty Limit=1 tablet/day
Prevacid Solutabs® ♣ Qty Limit=1 tablet/day
Prilosec® (brand) § Qty Limit=1 capsule/day
Zegerid® ♣ (omeprazole powder for suspension) § Qty Limit=1 powder packet/day
Zegerid® (omeprazole capsules) § Qty Limit=1 capsule/day

Gastrointestinal: Ulcerative Colitis Injectables

Length of Authorization: Initial PA 3 months; 12 months thereafter

Therapy-specific PA fax form available on OVHA website.

NO PA REQUIRED

PA REQUIRED

Remicade® (infliximab)

PDL Key:

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Glucocorticoids: Topical

Length of Authorization: duration of prescription, up to 6 months.

NO PA REQUIRED

ALCLOMETASONE† (compare to Aclovate®)
 DESONIDE† (compare to Tridesilon®)
 FLUOCINOLONE 0.01%† (compare to Synalar®)
 HYDROCORTISONE ACETATE† (all generics)

PA REQUIRED

Low Potency

Aclovate®*
 Cortaid®*
 Desonate® gel (desonide)
 DesOwen®*
 Hytone®*
 Synalar® 0.01%* (all products)
 Tridesilon®*
 Verdeso® (desonide foam)
 All other brands

Medium Potency

BECLOMETHASONE DIPROPIONATE† (compare to Alphatrex®)
 BETAMETHASONE VALERATE† (compare to Beta-Val®)
 DESOXIMETASONE 0.05%† (compare to Topicort®)
 FLUOCINOLONE 0.025%† (compare to Synalar®)
 FLUTICASONE TOPICAL† (compare to Cutivate®)
 HYDROCORTISONE BUTYRATE† (compare to Locoid®)
 HYDROCORTISONE VALERATE† (compare to Westcort®)
 MOMETASONE FUROATE† (compare to Elocon®)
 TRIAMCINOLONE ACETONIDE† (compare to Aristocort®)

Alphatrex®*
 Aristocort®* (all products)
 Beta-Val®*
 Cloderm® (clocortolone)
 Cordran®* (all products)
 Cutivate®*
 Dermatop®
 Elocon®* (all products)
 Kenalog® (all products)
 Locoid®
 Luxiq®
 prednicarbate† (compare to Dermatop®)
 Pandel®
 Synalar® 0.025 %* (all products)
 Topicort® 0.05 %* (all products)
 Westcort®* (all products)
 All other brands

High Potency

AMCINONIDE† (compare to Cyclocort®)
 AUGMENTED BETHAMETHASONE CREAM† (compare to Diprolene® AF)
 DESOXIMETASONE 0.25%† (compare to Topicort®)
 DIFLORASONE DIACETATE† (compare to Apexicon®, Maxiflор®, Psorcon-E®)
 FLUOCINOLONE 0.2%† (compare to Synalar®)
 FLUOCINONIDE† (compare to Lidex®)

Apexicon®*
 Cyclocort®*
 Diprolene® AF* (all products)
 Halog®* (all products)
 Lidex®* (all products)
 Maxiflор®
 Synalar® 0.2 %* (all products)
 Topicort® 0.25 %* (all products)
 Vanos®
 All other brands

Very High Potency

AUGMENTED BETHAMETHASONE OINTMENT† (compare to Diprolene®)
 CLOBETASOL PROPIONATE† (compare to Temovate®)
 DIFLORASONE DIACETATE EMOLL† (compare to Psorcon®)
 HALOBETASOL PROPRIONATE† (compare to Ultravate®)

Clobex®
 Cormax®
 Diprolene®* (all products)
 Embeline E®*
 Olux®/Olux E®
 Psorcon®*
 Temovate®* (all products)
 Ultravate®* (all products)
 All other brands

PDL Key:

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Growth Stimulating Agents

*Length of Authorization: 6 months initially, then up to 1 year; short bowel syndrome = 4 weeks.
Agents available after clinical criteria are met.*

Therapy specific PA form is available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

NORDITROPIN®
NUTROPIN®
NUTROPIN® AQ

OMNITROPE®

INCRELEX® (mecasermin)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Genotropin®
Humatropin®
Saizen®
Serostim®
Tev-Tropin®

Zorbtive® (with special criteria)

Hepatitis C Agents

Length of Authorization: 6 months

Therapy specific PA form is available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

RIBAVIRIN
RIBAVIRIN†

INTERFERON

PEGASYS® (peg-interferon alpha 2-a) (*QL* = 4 vials/28 days)
PEGASYS CONVENIENCE PACK® (peg-interferon alfa-2a) (*QL* = 1 kit/28 days)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

RIBAVIRIN
Copegus®
Ribasphere®
Rebetol®
INTERFERON
Infergen® (interferon alfacon-1)
Peg-Intron® (peg-interferon alpha-2b)
COMBINATION
Rebetron® (Rebetol/Intron-A)

Immunomodulators: Topical

****Caution not approved for use in children under 2 years old****

Effective 11/1/06: PA required for Elidel / Protopic for children < 2 years. Quantity Limit = 30 gm / fill, 90 gm / 6 mos. Step Therapy required (previous trial of topical steroid for patients ≥ 2 yrs). Protopic ointment concentration limited to 0.03% for age < 16 years old.

NO PA REQUIRED

ELIDEL® (pimecrolimus) §
PROTOPIC® (tacrolimus) §

PA REQUIRED

Elidel® (age < 2 yrs)
Protopic® (age < 2 yrs)

Lipotropics: Bile Acid Sequestrants

Length of Authorization: lifetime

NO PA REQUIRED

CHOLESTYRAMINE† powder (compare to Questran®)
CHOLESTYRAMINE LIGHT† powder (compare to Questran Light®)
PREVALITE† powder (cholestyramine light)

COLESTIPOL† tablets, granules (compare to Colestid®)

PA REQUIRED

Questran®* powder (cholestyramine)
Questran Light®* powder (cholestyramine light)

Colestid®* tablets, granules (colestipol)
Welchol® (colesevelam)

PDL Key:

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Lipotropics: Fibric Acid Derivatives

Length of Authorization: 1 year

NO PA REQUIRED

GEMFIBROZIL®† (compare to Lopid®)
♦TRICOR® (fenofibrate) §

♦PA required if patient not on concurrent statin

PA REQUIRED

Antara® (fenofibrate micronized) §
fenofibrate† §
fenofibrate micronized† §
Lipofen® (fenofibrate) §
Lofibra® (fenofibrate micronized) Capsules §
Lofibra® (fenofibrate) Tablets §
Lopid®* (gemfibrozil) §
Triglide® (fenofibrate) §

Lipotropics: Niacin Derivatives

Length of Authorization: n/a

NO PA REQUIRED

NIACIN†
NIASPAN® (niacin)
NIASPAN® ER (niacin)

PA REQUIRED

Lipotropics: Statins

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

LOVASTATIN† (compare to Mevacor®) (QL = 1 tablet/day (10 & 20 mg), 2 tabs/day (40 mg))

PRAVASTATIN† (compare to Pravachol®) (QL = 1 tablet/day (10 & 20 mg), 2 tabs/day (40 mg))

PA REQUIRED

Low/Medium Potency Statins

Altorev® (aka: Altocor®) (lovastatin) (QL = 1 tablet/day)
Lescor® (fluvastatin) (QL = 1 tablet/day)
Lescor® XL (fluvastatin XL) (QL = 1 tablet/day)
Mevacor®* (lovastatin) (QL = 1 tab/day (10 & 20 mg), 2 tabs/day (40 mg))
Pravachol®* (pravastatin) (QL = 1 tab/day (10 & 20 mg), 2 tabs/day (40 mg))
Pravastatin † 80 mg Tablet (use 40 mg tablets)

High Potency Statins

SIMVASTATIN† (compare to Zocor) (QL = 1 tablet/day)

AFTER GENERIC SIMVASTATIN TRIAL
CRESTOR® (rosuvastatin calcium) §
(QL = 1 tablet/day)

Lipitor® (atorvastatin) (QL = 1 tablet/day)
Zocor®* (simvastatin) (QL = 1 tablet/day)

Lipotropics: Miscellaneous/Combinations

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

ZETIA® (ezetimibe) § (AFTER CLINICAL CRITERIA ARE MET)
(Qty Limit = 1 tablet/day)

PA REQUIRED

Miscellaneous

Lovaza® (omega-3-acid ethyl esters)

Cholesterol Absorption Inhibitors/Combinations

ADVICOR® (lovastatin/niacin)

Vytorin® (ezetimibe/simvastatin) (QL = 1 tablet/day)

Other Statin Combinations

Caduet® (atorvastatin/amlodipine)

PDL Key:

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Miscellaneous: Elaprase® (Hunter's Syndrome Injectable)*Length of Authorization: 1 year***Quantity limits apply****NO PA REQUIRED****PA REQUIRED**Elaprase® (idursulfase) (*QL = calculated dose/week*)**Miscellaneous: Soliris® (Paroxysmal Nocturnal Hemoglobinuria Injectable)***Length of Authorization: Initial 3 months, Subsequent 1 year***Quantity limits apply****NO PA REQUIRED****PA REQUIRED**Soliris® (eculizumab) (*Quantity Limit = 20 vials total/3 months initially; 6 vials/month subsequently*)**Mood Stabilizers (see also Anticonvulsants)***Length of Authorization: duration of need***NO PA REQUIRED****PA REQUIRED**

EQUETRO® (carbamazepine)

LITHIUM CARBONATE† (compare to Eskalith®)

LITHIUM CARBONATE SR† (compare to Eskalith CR®, Lithobid®)

LITHIUM CITRATE SYRUP†

Eskalith CR®* (lithium carbonate SR)

Lithobid®* (lithium carbonate SR)

Multiple Sclerosis: Self-Injectables*Length of Authorization: 5 years***Quantity limits apply****NO PA REQUIRED****PA REQUIRED****Interferons**

BETASERON® (interferon B-1b)

COPAXONE® (glatiramer acetate) (*QL = 1 kit/30 days*)

REBIF® (interferon B-1a)

Other

AVONEX® (interferon B-1a)

Nutritionals, enteral*Length of Authorization: 6 months**Therapy specific PA fax form available on OVHA website.***NO PA REQUIRED****PA REQUIRED**PA applies to oral (swallowed) liquid nutrition: Contact MedMetrics.
For enteral nutrition requiring DME equipment and supplies call OVHA
Clinical staff for authorization.**Ophthalmics: Antihistamines***Length of Authorization: 1 year***NO PA REQUIRED****PA REQUIRED**KETOTIFEN† 0.025 % (eg. Alaway®, Zaditor® OTC, others)
(*Quantity Limit = 1 bottle/month*)**After trial of ketotifen 0.025 %**ELESTAT® (epinastine) (*Quantity Limit = 1 bottle/month*)PATADAY® (olopatadine 0.2 %)/PATANOL® (olopatadine 0.1%)
(*Quantity Limit = 1 bottle/month*)Emadine® (emedastine) (*Quantity Limit = 2 bottles/month*)Optivar® (azelastine) (*Quantity Limit = 1 bottle/month*)Zaditor® RX (ketotifen 0.025 %) (*Quantity Limit = 1 bottle/month*)**PDL Key:**

† Generic product

* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

Ophthalmics: Glaucoma Agents/Miotics

Length of Authorization: lifetime

NO PA REQUIRED

ALPHA-2 ADRENERGIC

ALPHAGAN® P (brimonidine tartrate)
BRIMONIDINE TARTARATE† (compare to Alphagan®)

BETA BLOCKER

BETAXOLOL HCl† (compare to Betoptic®)
BETOPTIC S® (betaxolol suspension)
CARTEOLOL HCl† (compare to Ocupress®)
LEVOBUNOLOL HCl† (compare to AKBeta®, Betagan®)
METIPRANOLOL†(compare to Optipranolol®)
TIMOLOL MALEATE† (compare to Istalol®, Timoptic®)

PROSTAGLANDIN INHIBITORS

Note: Coverage of a 'preferred' PI agent is contingent upon a 1st-line trial of any other preferred beta-blocker, a-2 adrenergic or CAI agent. Coverage of a 'non-preferred' PI agent is contingent upon a similar first-line trial as well as a failed trial of both preferred PI products.

LUMIGAN® (bimatoprost) §
TRAVATAN®/TRAVATAN Z® (travoprost) §

CARBONIC ANHYDRASE INHIBITOR

COSOPT® (dorzolamide w/timolol)
TRUSOPT® (dorzolamide)

MISCELLANEOUS

DIPIVEFRIN HCl† (compare to AKPro®, Propine®)
EPINEPHRINE† (compare to Epifrin®, Glaucon®*)
ISOPTO® CARBACHOL (carbachol)
ISOPTO® CARPINE (pilocarpine)
PILOCARPINE HCl† (compare to Pilocar®)
PILOPINE® (pilocarpine)
PHOSPHOLINE IODIDE® (echothiophate)

PA REQUIRED

Iopidine® (apraclonidine) - no PA required for pts <=10yrs
Betagan®*
Betimol®*
Istalol®*
Optipranolol®*
Timoptic®*
Timoptic XE®*

Xalatan® (latanoprost)
Azopt® (brinzolamide)

Miochol-E®
Miostat®
Pilocar®*
Propine®*

Ophthalmics: Mast Cell Stabilizers

Length of Authorization: 6 months

NO PA REQUIRED

ALAMAST® (pemirolast potassium)
CROMOLYN SODIUM† (compare to Crolom®, Opticrom®)

PA REQUIRED

Alocril® (nedocromil sodium)
Alomide® (iodoxamide)
Crolom®*

Ophthalmics: Non-Steroidal Anti-inflammatory Drugs (NSAIDS)

Length of Authorization: 1 year

NO PA REQUIRED

ACULAR® (ketorolac 0.5% ophthalmic sol.)
ACULAR LS ® (ketorolac 0.4% ophthalmic sol.)
ACULAR® PF (ketorolac 0.5% ophthalmic sol.)
FLURBIPROFEN † 0.03% ophthalmic sol.

PA REQUIRED

Diclofenac† 0.1% ophthalmic sol (compare to Voltaren®)
Nevanac® ophthalmic susp. (nepafenac 0.1%)
Xibrom® ophthalmic sol. (bromfenac 0.09%)
Ocufen®* ophthalmic sol. (flurbiprofen 0.03%)
Voltaren® (diclofenac 0.1% ophthalmic sol.)

PDL Key:

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Ophthalmics: Quinolone Anti-infectives

Length of Authorization: for date of service, no refills

NO PA REQUIRED

CIPROFLOXACIN HCl† (compare to Ciloxan®)
OFLOXACIN† (compare to Ocuflax®)

PA REQUIRED

Ciloxan®*
Ocuflax®*
Quixin® (levofloxacin)
Vigamox® (moxifloxacin)
Zymar® (gatifloxacin)

Ossification Enhancers

*Length of Authorization: lifetime
Quantity limits apply*

Therapy-specific PA fax form for Injectable Bisphosphonates available on OVHA website.

NO PA REQUIRED

ORAL BISPHOSPHONATES

BONIVA® (ibandronate) 150 mg (*Quantity Limit = 1 tab/28 days*)
BONIVA® (ibandronate) 2.5 mg *No quantity limits*
FOSAMAX® (alendronate)
FOSAMAX PLUS D® (alendronate/vitamin D)

PA REQUIRED

Actonel® (risedronate)
Actonel® w/calcium (risedronate/calcium)
Alendronate† (compare to Fosamax®)
Didronel® (etidronate)
Etidronate† (compare to Didronel®)
Skelid® (tiludronate)

INJECTABLE BISPHOSPHONATES

MIACALCIN® (calcitonin)

Boniva® Injection (ibandronate) (*Quantity Limit = 3 mg/3 months (four doses)/year*)
Reclast® Injection (zoledronic acid) (*Quantity Limit = 5 mg (one dose)/year*)

Fortical® (calcitonin)

Forteo® (teriparatide) (*Quantity Limit = 1 pen (3 ml)/28 days*)

Otic: Anti-Infectives

Length of Authorization: 1 year

NO PA REQUIRED

CIPRODEX® (ciprofloxacin 0.3%/dexamethasone 0.1%; otic susp.)
FLOXIN® (ofloxacin 0.3%; otic soln.)
NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE †

PA REQUIRED

Cipro-HC® (ciprofloxacin 0.2%/hydrocortisone 1%; otic susp.)
Ofloxacin† 0.3 % otic solution
Coly-Mycin S®/Cortisporin TC®
(neomycin/colistin/thonzium/hydrocortisone)
Cortisporin otic®/Pediotic®* (neomycin/polymyxin B sulfate /hydrocortisone)
otic solution/sus

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Parkinson's: Non-Ergot Dopamine Receptor Agonist

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

DOPAMINE PRECURSOR

CARBIDOPA/LEVODOPA† (compare to Sinemet®)
CARBIDOPA/LEVODOPA† ER (compare to Sinemet® CR)
PARCOPA® (carbidopa/levodopa ODT)

DOPAMINE AGONISTS (ORAL)

BROMOCRIPTINE† (compare to Parlodel®)
MIRAPEX® (pramipexole)
REQUIP® (ropinirole)

DOPAMINE AGONISTS (TOPICAL)

PA REQUIRED

Sinemet®*
Sinemet CR®*

Parlodel® (bromocriptine)

Neupro® Patch (rotigotine transdermal) (*QL = 1 patch/day*)

COMT INHIBITORS

TASMAR® (tolcapone)
COMTAN® (entacapone)

MAO-B INHIBITORS

SELEGILINE† (compare to Eldepryl®)

Eldepryl® (selegiline)
Azilect® (rasagiline) (*QL = 1 mg/day*)
Zelapar® (selegiline ODT) (*QL = 2.5 mg/day*)

OTHER

AMANTADINE† (compare to Symmetrel®)
STALEVO® (carbidopa/levodopa/entacapone)

Symmetrel® (amantadine)

Phosphodiesterase-5 (PDE-5) Inhibitors

Length of Authorization: 1 year

Quantity limits apply

Effective 7/1/06, phosphodiesterase-5 (PDE-5) inhibitors are no longer a covered benefit for all Vermont Pharmacy Programs for the treatment of erectile dysfunction. This change is resultant from changes set into effect January 1, 2006 and as detailed in Section 1903 (i)(21)(K) of the Social Security Act (the Act), precluding Medicaid Federal Funding for outpatient drugs used for the treatment of sexual or erectile dysfunction. Sildenafil will remain available for coverage via prior-authorization for the treatment of Pulmonary Arterial Hypertension.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Revatio® (sildenafil) (*Quantity Limit = 3 tabs/day*)
Viagra® (sildenafil) (*Quantity Limit = 3 tabs/day*)

Platelet Inhibitors

Length of Authorization: 3 years

NO PA REQUIRED

AGGREGATION INHIBITORS

CILOSTAZOL† (compare to Pletal®)
CLOPIDOGREL† (compare to Plavix®)
PLAVIX® (clopidogrel bisulfate)
TICLOPIDINE† (compare to Ticlid®)

PA REQUIRED

Pletal®*
Ticlid®*

OTHER

ASPIRIN†
DIPYRIDAMOLE† (compare to Persantine®)

Aggrenox® (dipyridamole/ASA)
Persantine®*

PDL Key:

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Psoriasis Injectables

Length of Authorization: initial PA of 3 months, 12 months thereafter.

Quantity limits apply

Therapy-specific PA fax form available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL® (etanercept)
RAPTIVA® (efalizumab)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Amevive® (alefacept)
Remicade® (infliximab)

Psoriasis: Non-Biologics

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

CYCLOSPORINE † (all brand and generic)
METHOTREXATE † (all brand and generic)
OXSORALEN-ULTRA® (methoxsalen)
SORIATANE® CK (acitretin)

PA REQUIRED

Oral

DOVONEX® (calcipotriene cream)
PSORIATEC®, DRITHO-SCALP® (anthralin cream)
TAZORAC® (azarotene cream, gel)

Topical

Taclonex® (calcipotriene/betamethasone ointment)
(QL for initial fill = 60 grams)

Pulmonary: Anticholinergics, Inhaled

Length of Authorization: 1 year

NO PA REQUIRED

METERED DOSE INHALER (SINGLE AGENT)
ATROVENT HFA® (ipratropium)
SPIRIVA® (tiotropium)

PA REQUIRED

NEBULIZER (SINGLE AGENT)
IPRATROPIUM SOLN FOR INHALATION

METERED DOSE INHALER (COMBINATION PRODUCT)
COMBIVENT® (ipratropium/albuterol)

NEBULIZER (COMBINATION PRODUCT)
DUONEB® (ipratropium/albuterol)

Ipratropium/albuterol† (compare to Duoneb®)

Pulmonary: Antihistamines - Intranasal

Length of Authorization: 1 year

NO PA REQUIRED

PA REQUIRED

Astelin® (azelastine) Nasal Spray
Quantity Limit = 1 bottle (30 ml)/25 days

PDL Key:

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Pulmonary: Antihistamines-1st Generation

Length of Authorization: 1 year

NO PA REQUIRED

All generic antihistamines

All generic antihistamine/decongestant combinations

PA REQUIRED

All brand antihistamines (example: Benadryl®)

All brand antihistamine/decongestant combinations (example: Deconamine SR®, Rynatan®, Ryna-12®)

Pulmonary: Antihistamines-2nd Generation

Length of Authorization: 1 year

NO PA REQUIRED

LORATADINE (OTC) † (compare to Claritin®)
CETIRIZINE† OTC (compare to Zyrtec® OTC)

FEXOFENADINE † (after loratadine OTC and certirizine OTC trials)

LORATADINE-D (OTC) †

LORATADINE (OTC) † syrup
CETIRIZINE† (OTC) syrup
ZYRTEC® OTC (cetirizine) SYRUP

LORATADINE (OTC) † chewable tablets

PA REQUIRED

Allegra® (fexofenadine)
Clarinex® (desloratadine)
Claritin® (loratadine)
Xyzal® (levocetirizine)
Zyrtec® RX/OTC* (cetirizine)

Allegra-D® § (12 HR & 24 HR)
Cetirizine-D† SR
Clarinex-D® § (12 HR & 24 HR)
Claritin-D® §
Zyrtec-D® §

Allegra® suspension
Clarinex® Syrup
Claritin Syrup®*
Zyrtec RX Syrup®

Cetirizine † Chewable Tablets
Clarinex Reditabs® §
Claritin Reditabs®*§
Zyrtec® Chewable Tablets §

Pulmonary: Persistent Asthma

Length of Authorization: 3 months after clinical criteria are met.

Therapy specific clinical criteria are available on the OVHA website.

NO PA REQUIRED

PA REQUIRED

Xolair® (omalizumab)

PDL Key:

† Generic product

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Pulmonary: Beta-adrenergic Agents

Length of Authorization: 5 years

Effective 11/1/06: Albuterol Sulfate MDI moves to "PA REQUIRED" (existing users of this product will maintain coverage without prior authorization indefinitely via grandfathering provisions)

NO PA REQUIRED

METERED-DOSE INHALERS (SHORT-ACTING)

XOPENEX® HFA (levalbuterol)

PA REQUIRED

- ◆ albuterol MDI†
Alupent® (metaproterenol)
Maxair® Autohaler (pirbuterol)
◆ Proair® (albuterol)
◆ Proventil® HFA (albuterol)
◆ Ventolin® HFA (albuterol)

◆ coverage grandfathered for current users

METERED-DOSE INHALERS (LONG-ACTING)

FORADIL® (formoterol) (*after criteria for LABA are met*)
SEREVENT® DISKUS (salmeterol xinafoate) (*after criteria for LABA are met*)

NEBULIZER SOLUTIONS (SHORT-ACTING)

ACCUNEB® (albuterol sulfate solution 0.63 mg/ml and 1.25 mg/ml)
ALBUTEROL 0.83 mg/ml neb solution †
METAPROTERENOL† neb solution
XOPENEX® neb solution (levalbuterol HCl) (age ≤ 12 yrs)

albuterol sulfate solution † 0.63 mg/ml and 1.25 mg/ml (compare to Accuneb®)
Xopenex® neb solution (age > 12 yrs)

NEBULIZER SOLUTIONS (LONG-ACTING)

Brovana® (arformoterol) *QL = 2 vial/day*
Perforomist® (formoterol) *QL = 2 vial/day*

TABLETS/SYRUP (SHORT-ACTING)

TERBUTALINE† tablets (compare to Brethine®)
ALBUTEROL † tablets/syrup
METAPROTERENOL †tablets/syrup

Brethine®* (terbutaline)

TABLETS (LONG-ACTING)

ALBUTEROL ER † tablets

Vospire ER®* (albuterol)

PDL Key:

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Pulmonary: Inhaled Glucocorticoids/Glucocorticoid Combinations

Length of Authorization: 5 years

NO PA REQUIRED

METERED DOSE INHALERS (SINGLE AGENT)

ASMANEX® (mometasone furoate) ((QL = 0.72 gm (3 inhalers)/90 days))
AZMACORT® (triamcinolone acetonide)
FLOVENT® DISKUS (fluticasone propionate)
FLOVENT® HFA (fluticasone propionate) (QL = 36 gm(3 inhalers)/90 days)
PULMICORT Flexhaler® (budesonide)

METERED DOSE INHALERS (COMBINATION PRODUCT)

ADVAIR® DISKUS (fluticasone/salmeterol)
ADVAIR® HFA (fluticasone/salmeterol)
SYMBICORT® (budesonide/formoterol) (QL = 30.6 gm (3 inhalers)/90 days)

NEBULIZER SOLUTIONS

PULMICORT RESPULES® (budesonide) (age ≤ 12 yrs)

PA REQUIRED

AeroBid® (flunisolide) §
AeroBid-M® §
QVAR® (beclomethasone) §

Pulmicort (budesonide) Respules® (age > 12 yrs)

Pulmonary: Nasal Glucocorticoids

Length of Authorization: 5 years

NO PA REQUIRED

FLUTICASONE Propionate † (compare to Flonase®)
FLUNISOLIDE†25 mcg/spray (previously Nasalide®)
NASACORT AQ® (triamcinolone AQ)
NASONEX® (mometasone)

PA REQUIRED

Beconase AQ® (beclomethasone AQ)
Flonase®* (fluticasone propionate)
flunisolide† 29 mcg/spray (compare to Nasarel®)
Nasarel® (flunisolide)
Rhinocort AQ® (budesonide AQ)
Veramyst® (fluticasone furoate)

Pulmonary: Systemic Glucocorticoids

Length of Authorization: 1 year

NO PA REQUIRED

CORTISONE ACETATE†
DEXAMETHASONE†
HYDROCORTISONE† (compare to Cortef®)
METHYLPREDNISOLONE† (compare to Medrol®)
ORAPRED® oral solution/ODT (prednisolone sod phosphate) (age < 12 yrs)
PREDNISOLONE† tabs / liquid (compare to Pediapred®, Prelone®)
PREDNISONE†

PA REQUIRED

Celestone®
Cortef®*
Medrol®*
Orapred® oral solution (age ≥ 12 yrs)
Orapred® ODT (age ≥ 12 yrs)
Pediapred®*
Prelone®*

Pulmonary: Leukotriene Modifiers

Length of Authorization: 1 year

NO PA REQUIRED

ACCOLATE® (zaflurkast)
SINGULAIR® (montelukast sodium)

PA REQUIRED

ZyFlo® (zileuton) §
ZyFlo® CR (zileuton SR) §

PDL Key:

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Pulmonary: RSV Prevention

Length of Authorization: 1 season, 6 doses (November 1-April 30)

Quantity limits apply

NO PA REQUIRED

PA REQUIRED: Therapy specific PA fax form is available on the OVHA website
SYNAGIS® (palivizumab)

Renal Disease: Phosphate Binders

Length of Authorization: n/a

NO PA REQUIRED

FOSRENOL® (lanthanum carbonate)
PHOS LO® (calcium acetate)
RENAGEL® (sevelamer)

PA REQUIRED

Rheumatoid & Psoriatic Arthritis: Immunomodulators

Length of Authorization: Initial PA of 3 months; 12 months thereafter

Quantity limits apply

Therapy specific PA fax form is available on the OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL® (etanercept)
HUMIRA® (adalimumab)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Kineret® (anakinra)
Orencia® (abatacept)
Remicade® (infliximab)

Saliva Stimulants

Length of Authorization: 1 year

NO PA REQUIRED

PILOCARPINE (compare to Salagen®)
EVOXAC® (cevimeline)

PA REQUIRED

Salagen®* (pilocarpine)

Sedative/Hypnotics

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

ESTAZOLAM† (compare to Prosom®)
FLURAZEPAM† (compare to Dalmane®)
TEMAZEPAM† (compare to Restoril®)

PA REQUIRED

Benzodiazepine

Dalmane®* (flurazepam)
Doral® (quazepam)
Halcion® (triazolam)
Prosom®* (estazolam)
Restoril®* (temazepam)
triazolam† (compare to Halcion®)

Non-benzodiazepine

CHLORAL HYDRATE† syrup, suppository
LUNESTA® (eszopiclone) (*Quantity Limit = 1 tab/day*)
ZOLPIDEM † (compare to Ambien®) (*Quantity Limit = 1 tab/day*)

Ambien®* (zolpidem) (*Quantity Limit = 1 tab/day*)
Ambien CR® (zolpidem) (*Quantity Limit = 1 tab/day*)
Rozerem® (ramelteon) (*Quantity Limit = 1 tab/day*)
Somnote® (chloral hydrate capsule)
Sonata® (zaleplon)

PDL Key:

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Skeletal Muscle Relaxants

Length of Authorization: 1 year

Effective 11/1/06: All carisoprodol products (brand and generics) move to "PA REQUIRED"

NO PA REQUIRED

CHLORZOXAZONE† (compare to Parafon Forte DSC®)
CYCLOBENZAPRINE† (compare to Flexeril®)
METHOCARBAMOL† (compare to Robaxin®)
METHOCARBAMOL, ASA† (compare to Robaxisal®)
ORPHENADRINE CITRATE† (compare to Norflex®)
ORPHENADRINE, ASA, CAFFEINE† (compare to Norgesic®, Norgesic Forte®)

ASA = aspirin

PA REQUIRED

Musculoskeletal Agents

Amrix® (cyclobenzaprine extended release)
carisoprodol †
carisoprodol, ASA†
carisoprodol, ASA, codeine †
Fexmid® (cyclobenzaprine)
Flexeril®*
Norflex®*
Norgesic®*
Norgesic Forte®*
Parafon Forte DSC®*
Robaxin®*
Robaxisal®*
Skelaxin®
Soma®
Soma Compound®
Soma Compound with Codeine®

Antispasticity Agents

BACLOFEN† (compare to Lioresal®)
DANTROLENE† (compare to Dantrium®)
TIZANIDINE† (compare to Zanaflex®)

Dantrium®*
Lioresal®*
Zanaflex®*

Smoking Cessation Therapies

Length of Authorization: see table

Quantity limits apply (maximum 2 courses per rolling 365 days)

NO PA REQUIRED

NICODERM CQ PATCH®
NICORETTE GUM®
COMMIT LOZENGES®
NICOTINE LOZENGE†
NICOTROL INHALER®

PA REQUIRED

nicotine patch OTC†
nicotine patch RX† (compare to Habitrol®)
Nicotine System Kit®
nicotine gum†
Nicotrol Nasal Spray®

ORAL THERAPY

BUPROPION SR†
CHANTIX® (varenicline) (Limited to 18 years and older, Quantity Limit = 2 tabs/day, maximum duration 24 weeks (2 x 12 weeks)/365 days)▲

Zyban®* (bupropion SR)
(maximum duration 24 weeks (2 x 12 weeks)/365 days)

▲ For approval of therapy beyond the established maximum duration, the prescriber must provide evidence that the patient is engaged in a smoking cessation counseling program.

PDL Key:

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Urinary Antispasmodics

Length of Authorization: 1 year

NO PA REQUIRED*

SHORT-ACTING AGENTS

OXYBUTYNIN† (compare to Ditropan®)

LONG-ACTING AGENTS

ENABLEX® (darifenacin)

OXYBUTYNIN XL† (compare to Ditropan® XL)

SANCTURA® (trospium)

VESICARE® (solifenacina)

PA REQUIRED

Ditropan®*

Flavoxate † (compare to Urispas®)

Urispas® (flavoxate)

>NOTE:

- Patients under the age of 65 must fail an adequate trial of generic oxybutynin before approval will be granted for either oxybutynin XL®, Vesicare®, Sanctura® or Enablex®.
- A therapeutic failure on at least two long acting preferred products is required before a PA will be approved on any non-preferred long acting medication.

Recipients < 21 years of age are exempt from all PA Requirements.

(Exception: An adequate trial of oxybutynin/oxybutynin XL will be required before approval of Ditropan®/Ditropan® XL will be granted)

Vaginal Anti-Infectives

Length of Authorization: 1 year

NO PA REQUIRED

CLINDAMYCIN

CLINDAMYCIN VAGINAL† (clindamycin vaginal cream 2%)

CLINDAMAX† (clindamycin vaginal cream 2%)

PA REQUIRED

Cleocin®* (clindamycin vaginal cream 2%)

Clindesse® (clindamycin vaginal cream 2%)

Cleocin® Vaginal Ovules (clindamycin vaginal suppositories)

METRONIDAZOLE

METRONIDAZOLE VAGINAL GEL 0.75%†

VANDAZOLE† (metronidazole vaginal 0.75%)

Metrogel Vaginal®* (metronidazole vaginal gel 0.75%)

Vitamins: Prenatal Multivitamins

Length of Authorization: 1 year

NO PA REQUIRED

All generics

PA REQUIRED

All brands

PDL Key:

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